Specialty Referral Requirements UnitedHealthcare Medicare Advantage Houston

Frequently asked questions

Members and PCPs working together to manage care

Some UnitedHealthcare® Medicare Advantage benefit plans require referrals for specialty care. These plans emphasize the role of the member's primary care provider (PCP). The PCP will manage referrals when a member seeks care from a network specialist or other health care professional. The PCP will also determine the appropriate number of visits and the timing for the referral and can submit additional referrals if a referral expires.

2022 update

For dates of service starting Feb. 1, 2022, UnitedHealthcare is reinstating the requirement for referrals from PCPs for members of certain plans in the Houston area. WellMed administers some processes for these plans and is updating the referral process for 2022.

Affected members of a referral-required plan

These members will have the Payer ID WELM2 listed on their UnitedHealthcare ID card.

Area	Plan name and type	Centers for Medicare & Medicaid Services (CMS) contract
Houston counties: Austin, Brazoria, Brazos, Fort Bend, Galveston, Grimes, Hardin, Harris, Jefferson, Liberty, Matagorda, Montgomery, Orange and Wharton	AARP® Medicare Advantage Plan 1 (HMO-POS)	H4527-037-000
	AARP® Medicare Advantage Plan 2 (HMO)	H4514-007-000
	AARP® Medicare Ally (HMO-POS)	H4514-014-000
	UnitedHealthcare® Chronic Complete Ally (HMO-POS)	H4514-015-000

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Referral requirements starting Feb. 1, 2022

- Referrals are required before a member can see most network specialists
- Referrals to network specialists must be submitted electronically by the member's assigned PCP or a PCP within the same provider group and tax ID number (TIN)
- The specialist must verify that the referral has been approved
- Referrals must be submitted before the services are rendered
- Referrals can be dated up to 5 calendar days before the date of submission
- A new PCP referral is needed when a member:
    - Needs to see another specialist (unless excluded)
    - Needs additional visits after the referral expires
    - Needs additional visits after using all the initial approved visits

In February, we'll watch to help ensure referrals are being submitted, but claim denials won't be issued before March 1, 2022, for missing referrals. We want to give PCPs time to become familiar with the new referral submission process.

We won't enforce referral requirements for Medicare Advantage plans during the national public health emergency period. We'll post the latest information about the national public health emergency at **UHCprovider.com/covid19.**

	**Referrals are required** for specialty care. The PCP must submit a referral before the member can receive specialty care. The member's PCP will submit referrals to WellMed by either: • Using the LeadingReach portal at **leadingreach.com/wellmed/pcp** • Using the WellMed ePRG at **eprg.wellmed.net**
	Members must **choose a PCP** or we will assign one to them. You'll find the PCP's name on the ID card, in the EDI 271 response transaction and when you verify eligibility. If the PCP is non-responsive, the specialist may ask the member to change their assigned PCP. The member may change their PCP through their online UnitedHealthcare account or by calling the Member Services number on their ID card.
	You can **find network specialists** using the directory at **UHCprovider.com/findprovider** or **wellmedhealthcare.com/search.** If you submit your request using the LeadingReach portal, you'll see a list of recommended network specialists.
	**Specialists are expected to confirm if a referral exists.** If the specialist doesn't verify that a referral is in place, claims may be denied and the member can't be billed. Coverage, cost share and benefits will be determined based on the member's benefit plan.
	**Prior authorization and admission notification** requirements still apply. Requirements are in the UnitedHealthcare administrative guide at **UHCprovider.com/guides** and at **UHCprovider.com/priorauth**.
	Referrals aren't required when **UnitedHealthcare is the secondary insurance carrier.**
	**Referrals are not required for facilities, ancillary providers or for certain services,** and these health care professionals should follow existing prior authorization protocols in the UnitedHealthcare **administrative guide** and applicable policies.

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How will members know about the referral requirement?

We explain the referral requirement in the member's plan documents. Members can check the status of their referral by calling the number on the back of their card.

What happens to members who are in treatment with a specialist before Feb. 1, 2022?

All members in active treatment can continue to receive treatment from their specialty physician until Feb. 1, 2022. Any visits after Feb. 1 will require a referral from the member's PCP.

When is a referral not required?

Referrals aren't required for facilities, ancillary providers or for certain services. Prior authorization may still be required for these services.

Eligible services that don't require referrals:

- Any service provided by a network PCP or network physician participating under the same tax ID as the member's PCP
- Any service from a network OB-GYN, chiropractor, optometrist, ophthalmologist, optician, podiatrist, audiologist, oncologist, nutritionist or disease management and infectious disease specialist
- Services performed while in an observation setting
- Allergy immunotherapy injections
- Mental health or substance use services with behavioral health clinicians
- Any services from a pathologist or inpatient consulting physician, including hospitalists
- Any service from an anesthesiologist, with the exception of pain management
- Services rendered in an emergency room, emergency ambulance or in a network urgent care center or convenience clinic
- Telehealth (virtual visits) for medical, behavioral and mental health services
- Medicare-covered preventive services, kidney disease education or diabetes self-management training
- Routine annual physical exams, vision or hearing exams
- Any lab services or radiological testing service, excluding radiation therapy
- Durable medical equipment, home health, prosthetic/orthotic devices, medical supplies, diabetic testing supplies and Medicare Part B drugs
- Additional benefits that may be covered by some Medicare Advantage plans but are not covered by Medicare, such as hearing aids, routine eyewear, fitness membership or outpatient prescription drugs

How many visits are included with each referral to a specialist?

Each referral may include 1–12 visits for up to 12 months. If the PCP does not indicate a number of visits, the referral is valid for 1 visit only for up to 12 months after the date it is electronically filed. After the visits are used or expire, the PCP may submit another referral to the network specialist for additional visits.

For members with certain chronic conditions, the online referral process allows standing referrals to be entered for 12 months instead of a specified number of visits.

Chronic conditions eligible for standing referrals of up to 99 visits:

- Allergy shots
- AIDS/HIV
- Amyotrophic lateral sclerosis
- Cancer
- Cerebral palsy
- Cystic fibrosis
- Epileptic seizure
- Fracture care*
- Glaucoma
- Myasthenia gravis
- Multiple sclerosis
- Parkinson's disease
- Renal failure (acute)
- Thrombotic thrombocytopenic purpura

* It's not necessary to specify the fracture care procedure performed on the referral.

How does the PCP select a specialist if a specialist has multiple addresses?

The referral will be based on the specialist's tax ID number (TIN), regardless of the displayed location. If the PCP doesn't indicate number of visits, the referral is valid for 1 visit only for a maximum of 12 months from the date it is signed or electronically filed.

What if a member requires care not available from a network specialist or facility?

If a member requires the services of a non-participating provider, the member's PCP can submit a prior authorization request for in-network coverage for services provided by non-network providers.

The referral and notification/prior authorization processes are separate.

Requirements vary by member benefit plan. You can find more information about notification/prior authorization requirements in the administrative guide at **UHCprovider.com/guides** and at **UHCprovider.com/priorauth.**

In accordance with member benefits and state regulations, we'll determine whether an in-network health care professional is available to treat the patient's condition. If one is not available, we'll determine if in-network benefits are available for services from a out-of-network specialist.

When a member is referred to a network specialist and that specialist identifies the need for the member to see another specialist or for the member to return for additional visits, does the member need a new referral?

If referring to a similar specialist (for instance, from a cardiologist to a cardiovascular surgeon), the specialist won't need the PCP to submit a new referral. The specialist can submit a referral:

- Using the LeadingReach portal at **leadingreach.com/wellmed/pcp**
- Using the WellMed ePRG at **eprg.wellmed.net**

If referring to a non-similar specialist, the referring specialist would ask the member's PCP to submit a new referral.

Who can I contact if I have questions about submitting referrals or the new PCP referral requirement?

For general questions regarding the LeadingReach online tool, you can contact **success@leadingreach.com.** For ePRG submission questions, PCPs should email **pcpinquiry@wellmed.net** and specialists should email **texasspecialists@wellmed.net.**

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